Kimberly Tangen PhD QME
Licensed Psychologist No. 22865
Clinical & Forensic Psychology
English-Spanish Bilingual
4519 Admiralty Way Suite 110
Marina Del Rey CA 90292
Tel: 323.538.4779
Fax: 323.978.6119
Email: kimberly@drkimberlytangen.com
Web: www.drkimberlytangen.com

HEALTH CARE PLAN BENEFITS & PAYMENT AGREEMENT

To bill your carrier for the health care treatment covered under your plan, complete this form. Also, fill out the highlighted portions of the Health Insurance Claim Form on the next page. Bring these forms and a photocopy of your insurance card to the first session.

1. **To determine what benefits you have available, call the customer service number listed on the back of your insurance card and request to be connected to the mental health department for verification of benefits. (If the back of the card has a number for the mental health department, then call that number.)**

Ask the following questions:

2. **"Is Dr. Kimberly Tangen an in network provider under my plan? I am calling to check on my psychotherapy (or psychological testing) benefits."**
3. **If the answer is YES, then ask the questions listed in column A (see below). Document the answers.**
   If the answer is NO, then ask the questions listed in column B (see below). Document the answers.

Column A	Column B
1. How much is my *"in network"* deductible?	**1.** Do I have "*out of network coverage"* for these services? **Y or N** **A.** If so, how much is my "*out of network"* deductible?
2. How much of my "*in network"* deductible remains for me to pay out of pocket?	**2.** How much of my "*out of network*" deductible remains for me to pay out of pocket?
3. What is my "*in network"* out of pocket maximum?	**3.** What is my "*out of network"* out of pocket maximum?
4. Do I need an authorization for this service? **Y or N** **If Yes, then ask:** **A.** What is the authorization number? _____ **B.** How many sessions are authorized to start with? **C.** What are the start and end dates of the authorized sessions? **START:** _____ **END:** _____ **D.** What is the maximum number of sessions that I am authorized for?	**4.** Do I need an authorization for this service? **Y or N** **If Yes, then ask:** **A.** What is the authorization number? _____ **B.** How many sessions are authorized to start with? **C.** What are the start and end dates of the authorized sessions? **START:** _____ **END:** _____ **D.** What is the maximum number of sessions that I am authorized for?
5. What is my copayment?	**5.** What is my copayment?
6. What is the address to send the claim to?	**6.** What is the address to send the claim to?
7. What is the address to send the treatment reports to?	**7.** What is the address to send the treatment reports to?

I authorize the release of information regarding my care to my health plan carrier for the payment of claims and other purposes related to the administration of benefits. I understand that it is my responsibility to pay for services not covered by my health plan whether because authorization was not obtained, denial, change or limitation of benefits, copay, deductible or other reason. I further understand that if there is an outstanding balance, I will make arrangements to pay the amount due.

_____ _____

Client (or Personal Representative) Signature **Print Name & Date**

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

PICA

1. MEDICARE ☐ (Medicare#) MEDICAID ☐ (Medicaid#) TRICARE ☐ (ID#/DoD#) CHAMPVA ☐ (Member ID#) GROUP HEALTH PLAN ☐ (ID#) FECA BLK LUNG ☐ (ID#) OTHER ☐ (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M ☐ F ☐

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self ☐ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street)

CITY | STATE

8. RESERVED FOR NUCC USE

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code) ( )

ZIP CODE | TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) ☐ YES ☐ NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? ☐ YES ☐ NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? ☐ YES ☐ NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☐ NO *If yes*, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? ☐ YES ☐ NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1										NPI	
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN ☐ EIN ☐

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) ☐ YES ☐ NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMB-0938-1197 FORM 1500 (02-12)